# Factors influencing triage decisions in mental health services

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## Abstract

The aim of the study was to identify the factors influencing the timing of an assessment after contact with a triage program in a community-based area mental health service in Australia. Triage decisions apparently were influenced by several groups of factors: patient characteristics; the source and mode of the contact with triage; and to a large extent by mental health service factors including the training, supervision and support of triage workers and the perceived availability of an assessment. While demand factors such as patient characteristics influenced the triage decision, supply factors also played an important role.

TRIAGE INCORPORATES rapid assessment, problem identification, determination of acuity and the deployment of the required resources to respond to the person's health needs. It aims to identify emergent or life-threatening disorders, regulate

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**What is known about the topic?**
Triage is an effective process for prioritising referrals, allocating resources quickly and managing demand.

**What does this paper add?**
This paper identifies that both demand (patient factors and source of referral) and supply (characteristics of the worker, perceptions of availability of an assessment and mode of contact) factors impact on the triage decision.

**What are the implications for practitioners?**
Practitioners can readily modify the supply factors to improve the quality of the triage decision in mental health services and manage demand more effectively.

the flow of patients through a service and use resources efficiently. It may be provided face-to-face, over the telephone, or through the use of technology such as the Internet. Triage is used in a range of health settings that require the accurate prioritisation and categorisation of patient treatment.

The use of triage in access to mental health care has had limited study. Patient characteristics, general medical practice and the psychiatric system may all influence the triage decision.[1,2] Emergency psychiatric services have evolved in some service settings to ensure that the people in urgent need can gain access to mental health care quickly. While emergency models can be effective,[3] their effectiveness also appears to be influenced by the overall mental health system within which they are located.[4]

Triage programs have their origins in emergency medicine. More recently, they have been used in primary care[5] and managed care.[6] The evaluation of NHS Direct, a 24-hour general health triage service staffed by nurses, demonstrated that telephone triage is widely used, callers mostly follow the triage advice, and there are

few adverse outcomes. However, it had little impact on the utilisation of other health services or overall cost.[7-9]

Mental health services in Australia are relatively well resourced[10] and the national mental health policy and plan are acknowledged globally as providing leadership in community-based care and integration with general health care.[11,12] Nonetheless, the demand for treatment from mental health services exceeds the available supply,[13,14] and there is substantial unmet need for mental health care more generally.[15] While there has been much debate about how mental health resources should be allocated, and calls for increased funding to expand services,[16] there has been limited exploration of the processes used by mental health services to respond to demand.

Mental health treatment in Australia is provided mainly by general practitioners with public sector mental health services (MHS) providing consultation, and direct treatment and care for those with more serious and complex problems. Entry to a specialist MHS in Australia relies on a triage process that decides on the priority of referrals, directs programs to manage emergencies quickly, and reduces the unnecessary use of resources.[17] Triage typically involves a patient or other person in a face-to-face or telephone contact with a mental health professional that determines whether and how quickly a person will receive a mental health assessment.

This study was conducted in Victoria where MHS are part of mainstream acute health services organised in geographically defined catchment areas. Access to the MHS, including acute inpatient care, case management and rehabilitation programs, relies on successfully negotiating a triage process. The aim of this study was to identify the factors that influenced whether, and how quickly, an assessment is provided after contact by or about a patient with a mental health triage program.

## Methods

A program evaluation design was used with three case studies illustrative of the triage programs.[18]

The case studies were conducted sequentially, with each case building on the previous findings. Case study one aimed to describe the program logic of triage and has been reported elsewhere.[19,20] M G was employed by the MHS in a senior management role at the time of the study. Case study two was a detailed description of the triage process. Case study three was a confirmatory phase. Ethics approval was obtained from institutional research and ethics committees at The University of Melbourne and at each of the participating of the MHS.

Policies, procedures and other relevant documentation were identified from key informants in all case studies and during a period of participant observation in case studies 2 and 3. The documentary evidence was used to map triage activities within each of the MHS.

Routinely collected information on contacts with triage (July–September 2000, MHS1; March 2001, MHS2; and July 2002, MHS3) were collated and analysed descriptively. Coding included site, time of contact, whether the contact concerned a current patient, source of the contact, reason for contact, whether an assessment was arranged, and outcome.

The contact charts for 1 week from two of the MHS (case study 1 and 3) were subject to a more detailed qualitative analysis. All contacts for people who were living in the catchment area and not currently case managed by the MHS were reviewed and divided into two categories: "assessed" and "not assessed". The assessed contacts were divided into two groups: those assessed within 24 hours and those whose assessment was scheduled for longer than 24 hours from the time of contact. Themes were identified descriptively and derived from both content and theory.[21]

Interviews with key informants such as consumers, carer organisations and general practitioners provided views of triage from the perspective of those with vital interests in the MHS. A semi-structured interview schedule was used that included questions about the informants' experience in using triage programs, understanding of triage systems, referral processes, factors that influenced the triage decision, and an

| 1 Pattern of contacts with triage service, MHS1 (Jul–Sep 2000) and MHS3 (Jul 2002) | | |
|---|---|---|
| | Contacts with triage service, no. (%) | |
| | MHS1 | MHS3 |
| **Current patient** | | |
| Yes | 1226 (947.1) | 527 (56.8) |
| No | 1220 (46.9) | 331 (35.7) |
| Unknown | 53 (2) | 34 (3.7) |
| Not patient-related | 104 (4) | 36 (3.9) |
| **Assessment** | | |
| Yes | 629 (24.2) | 113 (12.2) |
| No | 1220 (52.3) | 562 (60.5) |
| Not applicable | 597 (22.9) | 252 (27.2) |
| Unknown | 15 (0.6) | 1 (0.1) |
| **Outcome** | | |
| Support or information | 1155 (44.4) | 514 (55.4) |
| Referred to community mental health | 509 (19.6) | 194 (20.9) |
| Referred to psychiatric crisis team | 382 (14.7) | 93 (10.0) |
| Other assessment | 95 (3.6) | 20 (0.2) |
| Referred to another MHS | 90 (3.4) | 8 (0.9) |
| Referred to GP | 36 (1.4) | 8 (0.9) |
| Referred to emergency department | 34 (1.3) | 6 (0.6) |
| Referred to community agency | 45 (1.7) | 5 (0.5) |
| Referred to private psychiatrist | 41 (1.6) | 2 (0.2) |
| Referred to police/ ambulance | 16 (0.6) | 8 (0.9) |
| More information sought | 44 (1.7) | 3 (0.3) |
| Nil | 69 (2.7) | 29 (3.9) |
| Unknown | 87 (3.3) | 38 (4.1) |
| **Total** | **2603 (100)** | **928 (100)** |

MHS = mental health service.

overall estimate of the quality of triage programs. Participant observation[22,23] was conducted by MG in the second and third case studies, over a 4-week period in each case.

## Results

The triage programs were complex. Each involved mental health professionals from various disciplines and program areas, and operated from several geographical sites. None of the programs had a single point of accountability. In MHS1 (case study 1), for example, triage was managed by two community mental health services during usual business hours and a general hospital emergency department outside business hours. Triage in MHS2 (case study 2) involved a mixture of the community mental health service, a crisis team, mental health inpatient nurses and psychiatric registrars that depended on the time of day and the part of the service contacted. People who attended the emergency department were routinely referred to the triage program. In MHS3 (case study 3) triage was provided by the two community mental health services, the mental health after-hours nursing coordinators and the nurses working on an acute psychiatric inpatient unit. There was no general hospital emergency department within MHS3 catchment area, but referrals were frequently received from emergency departments in nearby areas.

### Routine information collection (MHS1 and MHS3)

Box 1 summarises the pattern of triage contacts at the MHS (Jul-Sep 2000, MHS1; Jul 2002, MHS3). Data from MHS2 was excluded because they did not document triage using a consistent format.

About half of the contacts with triage related to patients who were already receiving case management services. The MHS had developed some processes to ensure the continuity of care for existing patients: for example, the triage workers had a system for ready access to clinical files; there was a list of case managed clients; after-hours management plans for complex patients were developed; or case managers were encouraged to attend clinical reviews of triage contacts. However, none of the MHS had implemented comprehensive strategies to ensure the continuity of care of all existing patients.

**2 Source of contact with triage for patients who were not currently being case managed and likelihood of receiving a mental health assessment following contact with triage, Jul–Sep 2000 (MHS1) and Jul 2002 (MHS3)**

| Source of contact (referrer) | MHS1 | | MHS3 | |
|---|---|---|---|---|
| | Total contacts | No. (%) assessed | Total contacts | No. (%) assessed |
| Self | 224 | 76 (33.9) | 73 | 21 (28.8) |
| Carer | 235 | 78 (33.2) | 56 | 7 (12.5) |
| Primary care physician (general practitioner) | 49 | 31 (63.3) | 38 | 20 (52.6) |
| Community agency | 138 | 62 (44.9) | 27 | 6 (22.2) |
| Other MHS | 92 | 59 (64.1) | 36 | 14 (38.8) |
| Emergency department | 214 | 10 7 (50) | 0 | 0 |
| Police/ambulance | 43 | 22 (51) | 7 | 2 (28.6) |
| MHS (internal contacts eg, psychiatric registrar) | 9 | 5 (55.6) | 18 | 4 (22.2) |
| Other | 0 | 0 | 15 | 6 (40) |
| Total | 1004 | 440 (43.8) | 273 | 80 (29.3) |

MHS = mental health service.

Less than half of the contacts with triage resulted in an assessment from a mental health professional (Box 1). This was the case whether or not the people were currently being case managed. Box 2 summarises the source of contacts for people who were not currently being case managed and whether an assessment was recommended by triage.

While people seeking help for themselves or their families made many contacts with triage, less than a third of these contacts resulted in an assessment. In contrast, primary health care physicians (general practitioners) made fewer contacts (MHS1, 49; MHS3, 38) although a greater proportion of these contacts resulted in a recommendation for assessment (MHS1, 63%; MHS3, 53%) (Box 2).

### Qualitative data (MHS1, MHS2 and MHS3)

Triage workers frequently used the term "serious mental illness" when asked which mental disorders the MHS treated. This term was also found in policies describing the service entry criteria in all three case studies, although there was no clear definition of the term. The assessment of risk also appeared to be an important factor in the triage decision with phrases such as "no risk issues" frequently recorded in triage notes. However, formal risk assessments were rarely completed, even when the MHS had a policy requiring structured risk assessments for all triage contacts.

When asked by the researcher during participant observation, no triage worker stated that they had received any formal training in triage. Some triage workers had had extensive experience in mental health services, including triage, before commencing their current triage position. These workers generally felt competent to make triage decisions. Other triage workers were novices to triage, and indeed a few were new to mental health work generally. In some MHS they worked with experienced triage clinicians until they became confident with their decisions.

Each of the MHS had processes for the multi-disciplinary clinical review of triage decisions although the quality of the review processes was variable. There was minimal information about the triage contact available for the review and not all triage decisions were reviewed. None of the

services were using a structured triage decision-making tool.

The supervision of triage decisions was an important part of the learning process for triage workers, although this was usually an informal process with none of the MHS having a structured supervision program for triage workers. Informal processes were in place to support the triage worker. Colleagues were usually available to the triage worker for consultation and advice. Not surprisingly though, these support options were more limited overnight when, in some cases (such as inpatient nurses in MHS2), the least experienced mental health workers were responsible for triage. For example, one contact from a known patient to a triage worker who was simultaneously working on an inpatient unit documented that the patient was intoxicated and suicidal. The advice documented was "to drink two glasses of water and go to bed" (Case study 2: field notes).

The availability of assessments differed according to the time of day and location of the triage worker. For example, in MHS1 if a patient was assessed outside usual business hours as needing a mental health assessment but did not need it immediately, the person would be advised to contact the community mental health clinic during usual office hours. The triage worker did not routinely follow up to ensure that contact was made with the community mental health centre. In MHS2, the overnight triage worker advised people who needed an assessment immediately to attend the emergency department; others were required to contact the community mental health clinic during business hours.

While the mode of contact was not formally recorded in the triage data, it appeared that the large majority of triage contacts were made by telephone. The term "walk-in" was used to describe someone who presented in person to the triage worker. People frequently presented in person at general hospital emergency departments, and occasionally at the community mental health centres. If a person presented to the triage worker in person, they appeared much more likely to receive an assessment than those

| **3 Factors influencing the triage decision** | | |
|---|---|---|
| **Demand** | Patient factors | ■ Diagnosis |
| | | ■ Perception of risk |
| | | ■ Location (in/out of catchment area) |
| | Source of contact | ■ Self or carer |
| | | ■ Health professional (including primary care physician, general hospital emergency department) |
| **Supply** | MHS factors | ■ Triage worker (training, experience, role clarity, supervision) |
| | | ■ Perceived availability of an assessment |
| | | ■ Mode of contact (telephone/ face-to-face) |

who made contact by telephone. For example, in MHS2 all people who presented to the emergency department received an assessment. Similarly, people who attended the community mental health centre often received an assessment, even when the initial triage decision indicated that there was no evidence of a mental disorder.

## Discussion

A significant proportion of the contacts made with the triage programs concerned current MHS patients. While there were a number of different strategies used to promote continuity of care for some patients, none of the MHS used these strategies consistently. Mental health triage programs provide a significant component of the treatment for existing patients and MHS need to ensure that triage programs minimise fragmentation and promote coordination of care.

The triage decision appeared to be influenced by a range of factors including patient (demand), source of contact (demand) and the MHS factors (supply). These are summarised in Box 3. With a relatively small proportion of contacts with the triage program resulting in an assessment, minimising the impact of supply factors is important in

ensuring that the people who need specialist mental health services are able to access the appropriate assistance.

Some supply factors could be modified by the MHS to improve the quality of care. For example, increasing the availability of assessments would likely lead to an increase in the number of people recommended for assessment; and the use of a standardised triage protocol could increase the consistency of the decisions.

### Limitations of the study

Although the breadth of the study allowed an extensive evaluation of triage programs, it also limited the focus on specific issues. In addition, patient outcome data were not included in the study. The study design emphasised inputs and processes. The inclusion of outcome data would have contributed to the evaluation, although it would have expanded the scope of the initial study beyond what was feasible. Further work is needed in these respects.

## Conclusion

This initial study leads to a number of recommendations for establishing and managing mental health triage programs that are likely to be applicable beyond the services studied and beyond Victoria and Australia. The linkages between general health care and mental health services need to be clearly established and the lessons of triage from general health care should inform the development of mental health triage programs. Triage not only facilitated access to mental health treatment, but supported patients who were currently being treated. Triage workers need clear role descriptions, and it is important that other tasks they may be required to undertake are flexible and do not distract them from triage activity. It is essential that triage workers receive training in triage, including telephone assessment skills. The use of standardised protocols for triage decisions is likely to increase the quality and consistency of the triage decision. Ensuring the routine documentation of contacts and implementing supervision and clinical review processes are also critical.

One of the most important implications of the study is the apparent relationship between the triage decision and workload demands within the MHS. Effective triage relies on the MHS having the capacity to supply services.

While this study confirmed that demand factors such as patient characteristics influence the triage decision, supply factors also play an important role. In an affluent country, the way mental health services are organised and their relationship with other health service components evidently play a significant role in determining access to services. These factors are modifiable and can be monitored. Research and evaluation of this aspect of service provision is important for effective service provision and good use of available resources.

## Competing interests

The authors declare that they have no competing interests.

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